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MINDFUL MEDICAL PRACTICE AND THE THERAPEUTIC ALLIANCE

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ABSTRACT

This review article focuses on how the therapeutic relationship is central to clinician-client/patient relationships in psychiatry as well as other medical and psychotherapeutic encounters. Crucial to this relationship is the alliance formed between the caregiver and the person who seeks their care. The threats to the therapeutic alliance in psychiatry are discussed as is the importance of facing them. How mindfulness enables clinicians to build such bonds and foster well-being in themselves and in those they treat is examined in the context of quantitative and qualitative studies.

KEYWORDS: Mindful medical practice

“When I forget who I am I serve you
Through service I remember who I am
And know I am you.”

Hindu adage

THERAPEUTIC ALLIANCE

The therapeutic alliance is a collaborative relationship formed between therapist and patient/client. It is based on a secure and empathic affective bond which can promote positive outcomes¹. It is the central component of psychotherapies, either as the primary vehicle of change – for instance, in psychodynamic psychotherapies – or by enhancing techniques taught in cognitive-behavioural therapies. In the context of healthcare, the therapeutic alliance is embedded within the broader concept of a therapeutic relationship. It can take various forms (e.g. in face-to-face contact and telephone calls), be formed in different settings (e.g. in and outpatient services), and may last between a few minutes to decades². Siegel describes it under the rubric of attunement: a two-way relational process in which one person focuses on the inner world of the other, and the recipient of this attention feels understood, connected and felt. He underscores that self-attunement aids this process³.

ALLIANCE IN PSYCHOTHERAPY

Attachment theory proposes that an infant/child is able to become progressively more independent and explore the environment if there is a secure bond with an attachment figure. Sensitive and emotionally available caregiving enables a secure base to be formed that provides the infant/child with a sense of protection^{1,4}. Bowlby⁴ generalized this theory from human development to the processes underlying psychotherapy. The therapist may represent an attachment figure who offers a secure base so that the patient/client can engage in self-exploration and change maladaptive interpersonal patterns of behaviour. The therapist, while maintaining a warm acceptance and empathic understanding of the patient/client, provides a safe holding environment in which a secure attachment can be developed. As will be elaborated upon herein, the personal practice of mindfulness may aid therapists develop characteristics that can facilitate the establishment of an effective therapeutic alliance, such as being in the present moment, taking a non-judgmental stance, using self-awareness, self-care, and compassion in their work¹.

While patient/client engagement and retention in treatment are more likely when this approach is taken⁵, forming a therapeutic alliance can be quite challenging in the real world of clinical service. In psychiatric

practice in particular, there are various factors that interfere with the development of a therapeutic alliance. The mind-brain debate in psychiatry has led to a paradigm regarding the dominance of the brain and the hegemony of psychopharmacology. The therapeutic alliance, highly valued within psychoanalytical circles, has been overshadowed by complex biological models involving neurotransmitters, brain circuitries, and neuroanatomical functions of the brain. As a result, a patient may be told, "You are depressed because your serotonin levels are low. Take this antidepressant medication so that the concentration of this neurotransmitter increases in your brain, and you will feel better." In this scenario, a prescription is offered to solve the problem such that lengthy appointments and talk therapy are eliminated. Subsequent visits revolve mainly around monitoring medication use and its effects.

In many countries, health insurance reimbursements are higher and easier to obtain for drug treatment than psychotherapy. This has contributed to the increase in psychotropic drug sales and a shifting of treatment toward psychopharmacology⁶. In his book, *Unhinged: The Trouble with Psychiatry*, Carlat⁷ highlights that providing psychotherapy does not make economic sense. A doctor can see three or four patients per hour if s/he focuses on medications, but only one in that time period if s/he offers psychotherapy. The income differential is a powerful incentive for psychiatrists to leave psychotherapy to clinical psychologists or other clinicians who have extensive training and practical experience in psychotherapy⁸. As Eisenberg⁹ stated, psychiatrists seem to have rediscovered their medical roots, with the inherent rights and privileges including being licensed to write prescriptions. This act provides an edge in marketplace competition with the rapidly multiplying numbers of psychologists and social workers. "Psychiatry has begun to trade the one-sidedness of the 'brainless' psychiatry of the past for that of a 'mindless' psychiatry of the present."⁹ As a result, problems that used to be anticipated and accepted part of life (e.g. the death of a spouse, the impact of chronic illness) are now diagnosed and treated as mental disorders – resulting in a high prevalence of so-called mentally ill individuals with a 'chemical imbalance' who are given pills to reduce their suffering¹⁰.

Furthermore, in developing countries access to psychotherapy is limited for patients, while training for psychiatrists is scarce and expensive. For example, in Brazil recommendations of the Brazilian Psychiatric Association for the template of a residency program requires only 10% per year of the program to include psychotherapy¹¹. Supervisor training for psychotherapy in residency programs is not funded by public universities or in the hospitals where the programs are delivered. Supervisors have to fund themselves the high cost of training in psychotherapy^{12,13}. Thus, there is scant incentive to practice or be schooled in this essential aspect of treatment. Some textbooks used in psychiatric residency programs teach about doctor-patient relationship by emphasizing techniques to *manage the relationship* rather than develop a therapeutic alliance¹⁴.

ALLIANCE IN MEDICAL PRACTICE

In general medical practice forming a therapeutic alliance with patients can be challenging as well. Family physicians work under tight schedules and address an array of medical problems that vary from childhood asthma and immunization to cancer screening or an elder's congestive heart failure. In this context, forming a therapeutic alliance might not be viewed as a priority. In addition, fee-for-service remuneration motivates delivery of medical services quickly, on average during 8 to 12 minutes, which is incompatible with relationship building time slots¹⁵. Furthermore, medical care is part of a powerful medical-industrial complex comprised of pharmaceutical and insurance companies, testing laboratories, equipment and device makers – eager to expand the market¹⁰. Compounding these barriers, medicine has incorporated advanced technology. While this is essential for diagnosis and treatment, when it is used *exclusively* with the notion, “I can fix your body through evidence-based procedures” – the risk of omitting the relationship is apparent. It may be hard to remember to be present with the patient when interfacing with a computer screen. Administrative demands and record keeping may also influence how much time a doctor believes s/he can realistically spend with patients. Being efficient and seeing as many patients – as demanded by healthcare systems – may cloud the true mission of medical practice stated by Hippocrates: cure sometimes, treat often, and comfort always.

As a remedy to these ills in medicine, mindfulness may help clinicians develop characteristics associated with the establishment of an effective therapeutic alliance¹⁶. An inspiring example of mindful medical practice is presented by Marr, “When I walk into a patient's room, I like to drop it all and go in without an agenda. I like to use myself as an ‘instrument’ of care... I need to ‘calibrate’ myself to receive the information. I need to have a clear understanding of what is ‘my stuff’ and what is the ‘patient's stuff’.”¹⁷ Mindfulness has the potential to redirect one towards inner attitudes such as loving-kindness, equanimity, sympathetic joy, and compassion – all of which may translate into the notion, stated by D. Dobkin, a cardiologist, “I am my brother's keeper”¹⁸ when working with human beings who seek the care of a physician/psychiatrist.

MINDFULNESS IN CLINICAL PRACTICE

A quiet revolution has been taking place in the West¹⁹. During the 1960's, when those with youthful ideals aspired to change the world, they ventured out into it to learn more about who they were and how they could make a difference. Some journeyed east e.g. Alpert/ Ram Dass, who published: *Remember: Be Here Now*²⁰; Kornfield, who wrote: *A Path with a Heart*²¹, while others attended graduate and medical school^{22,24}; and some pioneered research that explored physiologic changes in people who meditated.^{25,26} Thirty years ago Kabat-Zinn designed a course entitled, Mindfulness-Based Stress Reduction (MBSR) for patients with

chronic pain and illness based on eastern practices and Buddhist psychology.²⁷ Herein we focus on mindfulness, not for patients, but for those who minister to their suffering: physicians, psychologists, nurses, and allied health care professionals (HCPs) summarizing how mindfulness impacts them personally and professionally.

Several texts have been published that examine how mindfulness can enhance psychotherapy, rather than medical practice, as such. Fulton's chapter in *Mindfulness in Psychotherapy*²⁸ examines how mindfulness can contribute to clinicians' training and work. He makes the link between meditation practice and the therapist's ability to notice when the mind wanders and to escort it back to the session; increased tolerance for affect – facilitated by the understanding that all is transitory (including unpleasant emotions); acceptance i.e. of the self, the other, and what is occurring. Importantly, meditation practice allows empathy to emerge and compassion to be its natural outcome. These attitudes result from the view of our common humanity i.e., seeing clearly that suffering is part of being alive and that we are all interdependent. Through the cultivation of equanimity one comes to accept what is. Thus, therapists learn to distinguish between what can be 'fixed' and what cannot. Fulton points out that meditation practice helps the therapist face the futility of over-identification and the freedom found in the realization that the self is a construction that is illusory.

There is a consensus that when physicians and other clinicians take a course such as MBSR they benefit personally.^{29,30} In a qualitative study Beckman et al.³¹ reported that primary care physicians felt less isolated, developed greater self-awareness and found meaning in their work following a 52-hour mindful communication program. These results were replicated by Irving et al.³² who conducted focus groups with clinicians (half of whom were physicians) following the Mindfulness-Based Medical Practice course (26 hours of an adapted version of MBSR). Those who took the course became more open and compassionate towards themselves and increases in mindfulness contributed to their well-being. Moody et al.³³ examined journal entries of clinicians working on pediatric oncology wards. Following an abbreviated (15 hours), modified MBSR course the clinicians, in the USA and Israel, experienced reduced stress and anxiety, improved inner peace, compassion, gratitude and joy even though their burnout rates remained high. Did this contribute to their work? The study did not address that question.

Gillitt's Master's thesis entitled, "The Mindful Therapist: An Interpretive Phenomenological Analysis of Mindfulness Meditation and the Therapeutic Alliance"³⁴ used interviews to determine *how* (not what) therapists' practice contributed to the alliance. Three main themes emerged: (1) self-care; (2) insights into the structures of selfhood; and (3) immediate mindfulness meditation during therapy. The first theme replicated what others have reported. Added was the concept of appropriate boundaries without concomitant guilt. The second theme highlighted the insight of the self within the context of interconnectedness. This translated into compassion and respect for clients/patients. Moreover, when the therapist was able to accept her/himself and see her/his own "essence" then it was easier to do so with others as well. Recognizing one's own limits (e.g. not knowing) opened vistas which included the other

being able to discover answers within him/herself. This led to a more collaborative style of interacting. For those who engaged in meditation-in-action *during* psychotherapy there was a sense of spaciousness, stillness, time seemed to slow down, and the therapist could employ the ‘body-felt sense’ to understand the other. Finally, therapist presence, enhanced by residing in the present moment, fostered a bond between the therapist and client.

An intriguing question was posed in a study conducted by Fatters and Hayes³⁴ with 100 trainees in psychotherapy. Seventy-eight supervisors rated trainees on their ability to manage countertransference. There was a significant relationship found between number of years meditating and three aspects of countertransference management: self-insight, self-integration, and empathy, as well as the total score ($r = .32, p = .01$) for this key skill. While the cross-sectional design conducted through email correspondence was a study limitation, using supervisors’ ratings was original, especially given trainees are unlikely to be able to rate their own countertransference. While the correlation between the total mindfulness score and countertransference was not significant, the subscale non-reactivity was with some subscales, (e.g. anxiety management and empathy). In the discussion the authors underscored the importance of emotional regulation and non-reactivity as likely by-products of meditation enabling the 47 trainees who reported experience with meditation to respond to patients in a therapeutic manner.

We contend that well doctors and other clinicians can foster healing in their patients.^{35,36,37} Is there empirical evidence for this hypothesis? While the literature is relatively sparse, in a critical review of the literature Escuriex and Labbé²⁹ reported that data from 20 studies were inconclusive with regard to whether clinicians’ mindfulness or meditation practices had a positive impact on patients’ outcomes. Yet, in a European clinical trial conducted by Grepmaier et al.³⁸ psychotherapists-in-training were randomized to a group taught Zen meditation (N=9 working with 63 inpatients) or not. The results indicated that the patients in the experimental group showed significantly better results e.g. they understood more clearly their own psychodynamics as well as the phenomenology and structure of their problems, and they scored lower on the SCL-90-R, indicating less psychological distress compared to the 61 inpatients treated by the psychotherapists not practicing Zen meditation. In another study, five therapist-patient dyads were interviewed together about their respective experiences of using mindfulness in therapy³⁹. Themes that emerged were: helpful in making the transition into the therapy session; it facilitated their dialogues, and it had a calming effect on both the therapist and patient.

In Padilla’s doctoral work⁴⁰ entitled, “Mindfulness in Therapeutic Presence: How Mindfulness of Therapist Impacts Treatment Outcome” 26 therapist/patient dyads were studied using self-report measures examining therapist personality, the working alliance, mindfulness, and patient outcomes, such as psychological distress (measured with the SCL-90) taken at the third session. The notion of mindfulness-informed psychotherapy, i.e. how the therapist’s personal meditation practice may influence how therapy is conducted was the underlying theme of the study. Meditation was proposed to reinforce open,

nonjudgmental and accepting attitudes, as well as to enable the therapist to tolerate suffering in the self and other such that s/he could be a 'container' of the patient's emotions. Correlations revealed that qualities of mindfulness were positively correlated with therapist and patient ratings of the working alliance. Moreover, the therapist's ability to accept without judgment was related to improvements on interpersonal problems. Yet, residual gains from the SCL-90 did not correlate with any of the therapist's mindfulness scores. Two methodological issues need to be kept in mind with regard to these and the other results (not detailed here): self-report measures were relied on exclusively and correction for multiple testing was not done, increasing the likelihood for Type I error.

In a multisite study of 45 clinicians (34 physicians, 8 nurse practitioners, and 3 physician assistants) treating 437 HIV+ patients, Beach et al.⁴¹ used the Roter Interactional Analysis System (RIAS) to assess the clinician-patient encounter. At baseline the clinicians completed the Mindful Attention Awareness Scale (MAAS)^{42,43}. The clinicians who scored higher on this scale were more likely to engage in patient-centered patterns of communication in which both clinicians and patients discussed psychosocial issues more and rapport building was enhanced. Likewise, the more mindful clinicians' emotional tone was more positive with patients. Consequently, patients gave higher ratings of clinician communications skills and were more satisfied with the encounter when being treated by the more mindful clinicians. This study is unique in that quality of care was determined based on *observations* of clinician-patient visits, and it included patients' reports concerning their perceptions of the quality of care they received. Rather than examining the clinicians' or patients' experiences separately, the dynamic between them was studied.

Yet, mindfulness is not a unitary construct even though many studies treated it as such when using the MAAS, which is considered to reflect one's disposition to be aware in the present moment. While there is not a consensus with regard to the definition of mindfulness nor how to measure it⁴⁴ the Five Facet Mindfulness Questionnaire (FFMQ) which includes five subscales: (1) Non-reactivity; (2) Observe; (3) Act with awareness; (4) Describe; and (5) Non-judgment is commonly used when examining which aspects of mindfulness contribute to the clinical encounter.

Ryan et al.⁴⁵ examined the effect of therapists' dispositional mindfulness on 26 patients with a variety of diagnoses (e.g. depressive or anxiety disorders, personality disorders) being treated with a brief psychodynamic-oriented intervention. The therapists were a mix of psychiatry residents, psychology interns, and licensed psychologists. In contrast to Grepmaier et al.³⁸, there was not a significant relationship found between therapists' mindfulness and patient improvements assessed with the SCL-90. However, therapists' total mindfulness scores and scores on 'Accept without judgment' were significantly correlated with patient improvements in interpersonal functioning.

Keane⁴⁶ studied a convenience sample of 40 psychotherapists who completed a postal survey which included the FFMQ as well as questionnaires pertaining to their work as therapists. Most reported that

mindfulness was related to their ability to: attend during sessions, tolerate affect, be self-aware and self-compassionate, be conscious of self-care needs, be empathetic, deal with the dynamics of transference and counter-transference. A positive association was found between mediation experience and the 'Non-judging' and 'Acting with awareness' facets of mindfulness. Empathy was correlated with 'Observe', 'Non-judging', and 'non-reactivity'. Mindfulness altered their understanding of therapy. Finally, they contended that their personal practice primarily affected the 'person of the therapist' and his/her ability to relate to others. However, its impact on patients was not examined.

In a recent cohort study with 27 clinicians carried out in Paris where MBSR was taught in a hospital setting, pre-and post-MBSR questionnaires assessed: burnout, depression, stress, meaningfulness, and mindfulness⁴⁷. Twenty-five patients independently rated their clinicians using the Rochester Communication Rating Scale (RCRS) before and after (n=18) a scheduled clinical encounter. Nine physicians audio-recorded consultations pre- and post-MBSR; the tapes were coded and analyzed by an independent team using the Roter Interaction Analyses System. Significant reductions in stress and burnout were found, as were increases in mindfulness and meaningfulness. Decreases in stress were correlated with less judgmental attitudes and less reactivity – two facets of mindfulness. Decreases in emotional exhaustion were correlated with more acting with awareness and less judgmental attitudes – two facets of mindfulness. Patients' perceptions of the clinical encounter indicated that patient-centered care increased post-MBSR. Decreased depersonalization (one aspect of burnout) was significantly associated with the RCRS subscale, "understanding of the patient's experience of illness." The audiotapes provided descriptive data suggesting agreement and mutual understanding between the doctors and their patients increased. At both time points doctors dominated the exchange and were patient-centered.

CONCLUSIONS

Despite its decline in emphasis, the therapeutic relationship is crucial across disciplines and various settings in which clinician-patient/client care takes place. Evidence is mounting that mindfulness enhances clinician characteristics vital to the therapeutic alliance and it positively impacts practitioners personally and professionally. Mindful Medical Practice enables clinicians to offer Whole Person Care as exemplified in *Mindful Medical Practice: Clinical Narratives and Therapeutic Insights*.³⁷ In the book 26 physicians and allied health care professionals from five countries describe how they were able to serve their patients/clients with generosity and compassion despite the many challenges they face working in various 21st century health care systems. We contend that they did so by connecting deeply with their patients/clients; consequently, they found their work to be meaningful and self-sustaining. ■

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